HOSPITAL
CHANGE OF OWNERSHIP PROCEDURES

1. Submit a notarized application along with the appropriate fee and a letter of intent 60 days prior to the anticipated Change of Ownership (CHOW) to the address at the top of the application. The letter of intent should include the name of the facility, the name of the seller\lessee of the facility, acknowledgment by the seller\lessee authorizing the sale or lease of the facility's operations and the projected date of the CHOW. Submission of a CHOW application indicates the acquisition and sale\lease of the entire facility operations including the associated license.

2. A letter will be sent acknowledging the receipt of the application, fee and notice of intent. Once the change of ownership has occurred and you receive the closing documents, you will need to send a copy of the bill of sale or the documents, including lease of operations agreements, that indicate that you are now the owner or lessee of the facility to:

   Office of Health Care Facilities
   665 Mainstream Drive, Second Floor
   Nashville, Tennessee 37243

3. This office will notify the regional office in your area to request their recommendation for the intended CHOW. The regional office will review the facility file to determine if a survey has been conducted within the previous fifteen (15) months with no outstanding deficiencies, and secondly to determine survey performance history including both scheduled and complaint surveys. If a survey has been conducted in the last fifteen (15) months and the facility's survey history including complaint surveys is satisfactory, a form recommending approval of the CHOW will be submitted to the central office in Nashville. If a survey has not been conducted within the previous fifteen (15) months or any complaint(s) rising to the level of a detriment to the health, safety, and welfare of the residents of the facility has been reported then; an on-site survey of the facility will be conducted. The regional office **will not** recommend approval of the CHOW, until an on-site survey is conducted with substantial compliance and/or deficiencies from either this on-site survey or a previous survey are corrected. The applicant/buyer will be notified by the regional office, if an onsite survey is necessary.

4. Once the recommendation is received in the central office from the regional office, a letter will be forwarded to you initially approving the CHOW pending the completion and submission of the final bill of sale (closing document(s)). The effective date of the CHOW will be the date of the closing document(s) is signed and dated by the seller/ buyer or lessee; or the date the regional office recommends approval of the CHOW, if occurring after the closing date. The application will then be presented to the Board for Licensing Health Care Facilities at the next regularly scheduled board meeting for ratification. If the Board ratifies the approval of the CHOW the license number listed above will become your permanent license number and a letter will be forwarded to you within three working days notifying you of the Board's final decision. You should receive your wall license within seven (7) to ten (10) business days thereafter.

5. If the Board does not ratify the initial approval of the CHOW, that initial authorization shall cease to be effective. A letter will be mailed to you providing an explanation and specific instructions as to any actions you may take to have the decision reviewed.

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at https://www.tn.gov/content/tn/health/health-program-areas/hcf-professionals/applications.html. Please check this website periodically for updates.

HOSPITAL
APPLICATION FOR CHANGE OF OWNERSHIP

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at https://www.tn.gov/content/tn/health/health-program-areas/hcf-professionals/applications.html. Please check this website periodically for updates.

Name of the Facility/Agency _____

Location of the Facility:

Street _____ City _____

County _____ State _____ Zip _____

Phone Number (____) _____ Fax Number (____) _____

Twenty-four (24) Hour Emergency Phone Number (____) _____

E-Mail Address _____

Total Bed Capacity _____

Administrator Information:

Administrator _____

Have you (Administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement or fraud)? Yes _____ No _____

If yes, what charge(s)? _____

Location of Conviction _____ Date _____
(City) (County) (State)

Mailing address if different from the Facility location address:

Name _____

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name _____ Phone Number (____) _____

Street _____

City _____ State _____ Zip _____

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE)

Bed Capacity	Fee	Bed Capacity	Fee
Less than 25	$1,040	100 thru 124	$2,080
25 thru 49	$1,300	125 thru 149	$2,340
50 thru 74	$1,560	150 thru 174	$2,600
75 thru 99	$1,820	175 thru 199	$2,860

Facilities with 200 beds or more shall pay a flat rate of $2,860 + $200 for each additional 25 beds or fraction thereof (i.e., 200-224 pays $3,060; 225-249 pays $3,260)

1. Check classification of institution for which application is made:

   ____ General Hospital ____ Orthopedic ____ Pediatric ____ EENT ____ Rehab _____ Chronic Disease _____ CAH

2. List the number of beds in each category, if applicable, for which acute care beds are utilized.

   Swing beds ____ Psychiatric Beds ____ Alcohol and Drug Abuse Beds ____ NICU ____ Rehab ____

3. Check type of services provided:

a	_____ Surgical	f.	_____ Chronic	k.	_____ ICU/CCU/NICU
b.	_____ Obstetrics	g.	_____ Orthopedics	l.	_____ Burn
c.	_____ Well Baby Nursery	h.	_____ Pediatrics	m.	_____ Trauma
d.	_____ Psychiatric	i.	_____ Rehabilitation	n.	_____ Cancer Treatment
e.	_____Alcohol and Drug	j.	_____ Emergency	o.	_____ Outpatient

4. If trauma was indicated above, what is the trauma designation? _____

5. What is the facility's pediatric emergency designation? _____

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:

   _____ Individual _____ Partnership _____ Corporation _____ Limited Liability Company

   _____ Church Related _____ Government/County _____ Other

   b. Check One: _____ For Profit _____ Non-profit

   c. Legal Entity checked in 1.a:

   Name _____ Phone Number (____) _____

   Address _____

   d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:

Name	Street	City, State, Zip
Name	Street	City, State, Zip

(If additional space is needed, please use a separate sheet)

2. a. In accordance with Rule 1200-08-01, is this CHOW a lease of operation? Yes____ No____

   b. If yes, please provide the lessor's information below:

   Name_____Phone Number (___) _____

   Address_____

3. a. Is your facility/organization accredited by a **federally approved** accrediting body including but not limited to JCAHO, CARF, etc.?

Yes _____ No _____ Expiration Date _____

b. Is your facility/organization deemed by a **federally approved** accrediting body including but not limited to JCAHO, CARF, etc.?

Yes _____ No _____ Expiration Date _____

4. If you have a parent company please provide the following information:

Name _____ Phone Number (_____) _____

Address _____

5. a. Are any owners of the disclosing entity or also owners of other health care facilities in Tennessee and/or other states? Yes ____ No ____

b. If yes, list names and addresses of all such facilities: ***(If additional space is needed, please use a separate sheet)***

_____

5. a. Do you have a contract with a management firm to operate this facility? Yes _____ No _____

If yes, specify dates: From _____ To _____

b. If yes, specify name of firm: _____ Phone Number (_____) _____

_____

Street City, State, Zip

6. a. Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state? Yes _____ No _____

b. If yes, where? _____ When? _____

c. For what reason? _____

VERIFICATION BY NOTARY PUBLIC:

Signee for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) § 68-11-201.

Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA § 71-6-103 to report incidents of abuse or neglect.

Signee acknowledges that the State of Tennessee may share information regarding the activities and compliance of the licensee, if the submitted CHOW application is a lessor and/or lessee transaction as described in the above Ownership of Business section of this application.

Applicant Signature | Title or Position | Date

STATE OF TENNESSEE

County of _____

The above named applicant (print name) _____, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this _____ day of _____
Month Year

Notary Public: _____

My commission expires: _____